Department of Mental Health (DMH)
Mental Health Services Act (MHSA)
Community Services and Supports Component
Stakeholder Input Process

Workgroup: CSS DRAFT Plan Requirements II,
Sections V - IX
March 23, 2005

Meeting Summary
For Discussion Only

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I. Background

The Mental Health Services Act (MHSA) became state law on January 1, 2005. The passage of the Act has created the expectation of a comprehensive planning process within the public mental health system. The multiple components of the MHSA are designed to support one another leading to a transformed culturally competent mental health system. This is reflected in the California Department of Mental Health's *Vision Statement and Guiding Principles for DMH Implementation of the Mental Health Services Act* of February 16, 2005: "As a designated partner in this critical and historic undertaking, the California Department of Mental Health will dedicate its resources and energies to work with stakeholders to create a state-of-the-art, culturally competent system that promotes recovery/wellness for adults and older adults with severe mental illness and resiliency for children with serious emotional disorders and their families. In its implementation responsibilities under the MHSA, DMH pledges to look beyond "business as usual" to help build a system where access will be easier, services are more effective, out-of-home and institutional care are reduced, and stigma toward those with severe mental illness or serious emotional disturbance no longer exists."

On February 15, 2005, DMH released a draft of the Program Plan Requirements for the Mental Health Services Act (MHSA) Community Services and Supports (CSS) component (referred to throughout this summary as "the CSS DRAFT Plan Requirements"). DMH scheduled three sessions to obtain broad-based stakeholder input on components of the document. The CSS DRAFT Plan Requirements were drafted with the explicit intention of providing a document to which stakeholders could respond as part of the process of developing final requirements for the counties.

The workgroup held on March 23, 2005 in Sacramento was the second of three related workgroups to solicit stakeholder feedback on the CSS DRAFT Plan Requirements. The first workgroup meeting covered the first four sections, I – IV, while this second workgroup covered Sections V, VI, VII and IX. The March 30 workgroup will cover Section VIII and other financing issues relating to CSS.

A client and family member (CFM) pre-meeting, held from 9:30 – 11:30 a.m., provided an opportunity for clients and family members to discuss the afternoon workgroup session purpose, review the workgroup agenda, ask questions, provide feedback and network with each other. Both the pre-meeting and the workgroup session were introduced with the same general overview. The workgroup was held from 1:00 – 4:00 p.m.

At the first CSS workgroup session on March 7, participants self-selected to participate in one of four age-based discussion groups: children and youth, transition-age youth (16 – 25 years), adults, and older adults. Participants were encouraged to participate in the same age-group discussions on both March 7 and 23 in order to have continuity in the feedback process.

The first two hours of the March 23 workgroup sessions were held in the age-based groups. The four age groups reconvened as one large group for the last hour of the meeting, at which time each age-based group presented its list of key concerns and strengths of the overall CSS DRAFT Plan Requirements.

Sixty-two (62) people attended the morning client and family member (CFM) pre-meeting and 150 attended the afternoon workgroup.

A. Anticipated Outcomes

The outcomes of the workgroup meeting were:

1. To identify areas where CSS DRAFT Plan Requirements Sections V – IX are not consistent with the intent and purpose of MHSA, DMH's vision statement and guiding principles.

2. To identify areas of the CSS DRAFT Plan Requirements Sections V – IX that are unclear or confusing.

3. To identify strengths and concerns in CSS DRAFT Plan Requirements overall.

B. Schedule of Meetings

Upcoming workgroup and conference call dates are:

- Wednesday, March 30: third meeting in the series on CSS, covering financing, including Section VIII of the CSS DRAFT Plan Requirements. The pre-meeting will begin at 9:30 a.m. and the workgroup at 1 p.m. at the Holiday Inn Capitol Plaza in Sacramento. Materials for this meeting have been posted on the DMH website.

- Tuesday, April 5 and Wednesday, April 6: second general stakeholder meetings. Each of these meetings will cover the same materials and have been divided into north and south locations to make each meeting more accessible. Participants need only attend one of these meetings. There will be one combined summary of both meetings, as though it were one meeting. The Los Angeles meeting will be held at the Burbank Hilton Hotel; the Sacramento meeting will be held at the Holiday Inn Capitol Plaza. The meeting will include a discussion about progress in the stakeholder process and in MHSA implementation since the December 17, 2004 general stakeholder meeting. DMH will discuss what approach they will use to address these concerns and recommendations.

- Another set of workgroup meetings on new topics will be scheduled for April, May and June, followed by another general stakeholders meeting in July.

II. Client and Family Member Pre-Meeting (9:30 – 11:30 am)

Sixty-two (62) people attended the morning Client and Family Member (CFM) pre-meeting.

Bobbie Wunsch, Pacific Health Consulting Group and facilitator of the MHSA stakeholder process, introduced the Client and Family Member session by reminding people of upcoming dates for the MHSA stakeholder input, listed above.

Ms. Wunsch thanked everyone who had provided feedback both at and following the March 7 and 16 workgroup meetings and who completed the CFM survey, designed to gather input on how best to structure the pre-meetings, which was circulated at the March 16 meeting. Ms. Wunsch disseminated copies of the survey summary, which is posted on the MHSA website. Based on the CFM survey, many clients and family members view the pre-meeting as an opportunity to review the agenda for the afternoon workgroup and to orient to the workgroup topic. Other clients and family members want to use the pre-meetings to work together, with a client or family member leader facilitating, to address important issues related to the workgroup. In the future, the pre-meeting format will vary at the different workgroup meetings, depending on the focus of a particular workgroup. Ms. Wunsch reviewed the structure for today's meeting which would involve a brief initial meeting as one large group and then smaller age-based group discussions facilitated by CFM facilitators.

Before breaking up into age-based work groups, the entire CFM group reviewed the agenda for the afternoon meeting. Carol Hood, DMH Deputy Director, responded to a number of questions raised at the March 16 pre-meeting and entertained a series of additional questions, summarized below. In addition, the entire CFM group was presented with brief highlights of position statements on either MHSA or the CSS DRAFT Plan Requirements from client and family member advocacy groups. Pam Hawkins spoke on behalf of the United Advocates for Children of California (UACC), Sally Zinman for the California Network of Mental Health Clients (Client Network), and Ralph Nelson, M.D., for the National Association for the Mentally Ill – California (NAMI). These position papers were distributed and are available on the DMH website.

Before breaking into four age-based groups, Ms. Wunsch introduced four client and family member advocates who facilitated the second portion of the pre-meeting: Joan Beesley, Children and Youth Group; Sharon Kuehn, Adult Group; Tina Wooton, Transition-Age Youth Group; and Daphne Shaw, Older Adult Group. The remainder of the CFM pre-meeting was spent in these age-based discussion groups. Facilitators were encouraged to work with their groups identifying areas of major concern and areas of strength in the CSS DRAFT Plan Requirements, and also to provide the opportunity for clients and family members to address other related issues.

A. Feedback from DMH

Ms. Hood discussed how DMH will incorporate the feedback provided at the workgroup meetings into the CSS DRAFT Plan Requirements. DMH staff have begun to summarize feedback from letters, position statements, emails and telephone calls to the toll-free number and to combine it with the written summaries from the workgroup sessions. Starting on March 24, the MHSA team will begin to review and evaluate all the feedback, and prepare recommendations on final CSS Plan Requirements to Stephen Mayberg, Ph.D., DMH Director.

The timeline for feedback has been extended from April 1 to April 11, to provide more time after the general stakeholders meetings on April 5 and 6 for additional feedback. At these general stakeholder meetings, DMH will summarize the major points raised in the workgroups and identify the major approaches for addressing them. The final CSS Plan Requirements will be issued by May 1, 2005.

In response to questions raised and recommendations made at the March 16 workgroups, DMH staff researched several issues:

- *Request for dependent care expenses.* DMH will reimburse for dependent care, up to $100 per client or family member who is sponsored by one the statewide advocacy organizations per meeting, as needed.

- *Request for food or coffee*. DMH staff conferred with department fiscal and human rights staff about whether refreshments could be provided at meetings as reasonable accommodations under the Americans with Disabilities Act. Staff denied the request, concluding that it is against state law for state agencies to provide such items. DMH staff acknowledged the frustration regarding the situation and encouraged participants to bring their own food.

- *Education and training to help clients and family members participate actively in the MHSA planning processes*. At the March 16 Short-Term Strategies Workgroup, education and training for clients and family members so that they could fully participate in the MHSA planning processes was identified as important to implement as quickly as possible. Since March 16, DMH has already solicited a collaborative proposal from UACC, Client Network, NAMI and the Mental Health Association to provide this training, with a requirement that the organizations reach out beyond their current constituencies and members.

- *Examples of how CSS requirements could be organized around specific services*. At the March 7 workgroup, a request was made for DMH to provide concrete examples of how specific services could be described based on the components of the CSS DRAFT Plan Requirements. In response, DMH developed examples by age group of how particular service models might fit into the components of county plans. These examples were intended to paint a picture for what the county plan could look like and to help participants understand how the logic model could work. Copies were

distributed at the meeting and are posted on the website. DMH staff emphasized that these are examples only, not prescriptions for what counties should do.

B. Client and Family Member Questions and Comments

CFM Question: How does one find documents on website?
DMH Response: Go to www.dmh.ca.gov, click on MHSA box on the right side of the screen.

CFM Question: Are all the documents from today going to be on the website?
DMH Response: Yes. They are also available at the registration desk.

CFM Question: What if a person does not have the ability to download the materials?
DMH Response: The materials will be available at meetings. Let the registration desk know, or phone the DMH office and DMH will add your name to the mailing list of people who are sent hard copies.

CFM Question: What is the MHSA email address?
DMH Response: MHSA@dmh.ca.gov. It is a central e-mail, which is monitored by one DMH staff member who either responds immediately or forwards it to the appropriate staff.

CFM Question: What is the process for the final version of the CSS DRAFT Plan Requirements?
DMH Response: DMH will summarize major points from the workgroups and stakeholder meetings and explain the initial approaches to address them at the general stakeholder meetings on April 5 and 6. The final CSS Plan Requirements will be issued by May 1.

CFM Question: How can people obtain copies of materials if they do not have internet access? I have contacted the Department about this and have not received materials.
DMH Response: There are systems in place that should assure that everyone who has requested hard copies receives them; DMH will review the process and follow-up with those who have requested hard copies of materials.

Other Comments

CFM Comment: There were many people of color at the cultural competence workgroup. As we look around today, we do not see anything like those numbers. We need to develop strategies to bring those people back. This is a major lapse.

CFM Comment: There are people who would come if DMH or their county provided funding to come. We need accommodations about food.

C. Client and Family Member Pre-Meeting Age-Based Group Discussions

1. Children and Youth

Facilitated by Joan Beesley, the children and youth discussion reviewed Sections V, VI, VII and IX of the CSS DRAFT Plan Requirements, as well as the key concerns and strengths about the draft overall.

Pam Hawkins talked in more detail about the *UACC Recommendations for MHSA* position paper.

- UACC's comprehensive position paper is not yet complete. UACC has an extensive process across California, soliciting feedback and gathering family input from all over the state. It is a difficult, complicated process, with so many people's input.
- The original document was passed out at the workgroup meeting. It is also available online (http://uacc4families.org/). When the new UACC document comes out, it will review the CSS DRAFT Plan Requirements in more detail.
- Due to limited time, UACC picked the word "resiliency" as a focus of today's comments. UACC is sensitive to anything that sounds blaming and is sensitive to the common attitude that "parents must not have done the best…" to make their children resilient.
  All areas of community environments affect experiences of a child (schools, family, home, foster care, jail, etc). It is not just the fault of parents when children are not resilient.
- UACC suggested changes to the bulleted strategies, but mostly to structural strategies such as wraparound, CSOC, etc. Instead of giving a menu of services, UACC suggests using the core values of CSOC, or to use models that have transformed the qualities of the services provided. All build on hope and foster resilience.
- UACC sees a problem with how to capture accountability in enrollee-based programs. This does not work for children. For example, suppose one outcome is, "Increased school attendance and reduction in juvenile hall recidivism…." Then the enrollee-target becomes children in juvenile hall. But the overriding goal should be that children never reach that point.
- UACC identifies services for youth that use evidence-based practices designed to keep them out of juvenile hall. UACC hopes that counties will see that this is a high priority group. UACC calls for more specific age-based programs than an enrollee program.
- UACC wants the mental health system to be aware of the children entering transition ages, and promote programs that focus on transitional skills.
- UACC is always available for questions – email Pam Hawkins at phawkins@uacc4families.org or call (916) 643-1534.

Section V – System Transformation/Capacity Funding

Enrollment

- If counties already provide wraparound services, it is easy to implement an enrollee-based system.
- Flexibility of doing both enrollment-based and system capacity as planning tools is positive.
- Difficult to do an enrollment-based system across the county, because the outcomes are still unknown.
- Need guidance on how to measure outcomes for non-wraparound enrollee-based services. When there is a small number of enrollees, especially in small counties, the measurable outcomes will not appear very impressive relative to the amount of expenditures.
- AB 3632 children will not be enrolled children. It is not clear how to provide the family partnership programs to them. Our county does not want to be limited to having only enrollee-based clients.

Quality

- There is concern that the mandate to hold to the values of Children's System of Care will not be viable with limited funds: will there be adequate funding when system capacity funds do not lend themselves as easily to evidence-based and values-driven programming?
- In some cases, mental health agencies that accept Medi-Cal offer higher quality services than what can be found through conventional insurance. Many cannot find quality mental health coverage through Blue Shield, for instance, whereas Medi-Cal does cover mental health.
- Sometimes workers are not paid enough to want to stay on the job. Often the only providers willing to work in public programs are not good (for example, the good providers do not take Medi-Cal).
    - **DMH Response:** In your proposal, consider whether you are going to be able to recruit and retain qualified staff and develop strategies to achieve that.

Supplantation

- If a county loses Children's System of Care and adds MHSA, or uses MHSA funds to match Medi-Cal, how is that not supplantation?
    - **DMH Response:** That depends on the definition of supplantation. Counties use different strategies for matching Medi-Cal; DMH has no legal authority around this. DMH will develop non-supplantation guidelines, so the money does not slip away. Ambiguity will lead to lawsuits, so DMH is taking care to be on solid grounds. Because of the void in information, people are concerned about supplantation.

Family Partnership Programs

- Family Partnership Programs: if DMH is looking for family-run support programs, it should also look for those that have full transition-age youth support commitment. Add this to the language.
- If you try to implement family partnership programs, how can you ensure system of care values with system capacity funding?

Other Concerns

- Clarify program funding and how to determine whether certain programs are enrollment-based or system capacity.
- If you try to go too broad, you do not capture the most critical needs.
- The example of the CSS plan handout shows that DMH is listening to us.
- In the distribution of funds, should there be an allocation of a minimum percentage per age group?
  - **DMH Response:** That is not in our proposal.
- Need more transition services. For example, no one is following up on medications when youth exit juvenile hall. Counties will need aftercare, step-down and transition strategies for transition-age youth.
  - **DMH Response:** We are trying to give counties ideas for different kinds of new services. This is not meant to be an exhaustive list, but directions for promising practices and evidence-based strategies.

<u>Section VI – Assessing Capacity</u>

Major Strengths

- Document is comprehensive and inclusive.

Concerns

- Create a system that supports self-identification issues.
- Trying to fit clients into the right category is stigmatizing. Why separate client and family member staff from other staff in the Staffing Capacity list? Other than for statistical reasons (i.e., to prove you are hiring them), it creates a separation of client and family member staff from others. It is intimidating as a family member to have to self-identify.
- If the state has to hire a client, s/he is hired due to client and family member experience rather than having experience and education in that area of expertise.
- Is there capacity for volunteer workers in order to have MHSA funds?
  - **DMH Response:** Yes, but with volunteers, there are obstacles with issues such as fingerprinting. You can run peer-support programs and interagency programs; counties can partner with these groups, etc. That's the idea of system transformation.
- Can one person be identified in more than one category in the Staffing Capacity list in Exhibit 1?
  - **DMH Response:** Yes.

Section VII – Work Plans

Major Strengths
- It is comprehensive and inclusive.

Major Concerns
- It requires critical implementation dates, which is a huge and scary issue.
- Need more guidance on the workplan.

Section IX – Local Review and Public Hearing

- Are there specific criteria for local public Mental Health Board review?
  - **DMH Response**: Some counties will also have to go through their Board of Supervisors because the amount of money is so large. However, "documentation of public hearing" in this section refers to the local mental health board or commission, not to be confused with the Board of Supervisors.

Summary of Key Concerns about the CSS DRAFT Plan Requirements: Children and Youth CFM Pre-Meeting

The children and youth discussion group summarized its overall concerns of the CSS DRAFT Plan Requirements as follows:

1. *Need clarification on system capacity versus enrollee funding.* Generally people had difficulty on the clarification of finer distinctions in Section V. There is strong resistance to enrollee-based programs.
2. *Outcomes.* Need guidance on how to measure outcomes for non-wraparound and enrollee-based services. When there is a small number of enrollees in a program (especially in small counties), the measurable outcomes will not appear very impressive relative to the amount of expenditures.
3. *Clients and family members hired as staff.* Need stronger language regarding hiring criteria, including pay and benefits, and mechanisms for fitting clients and family members into existing civil service job classifications. In consideration of qualifications, years as a client or family member should count for job experience, in addition to other credentials. Also, the system should support self-identification of clients and family members as staff while reducing stigma. Separating client and family member staff from other staff adds to stigma.

Summary of Major Strengths of the CSS DRAFT Plan Requirements and the Stakeholder Process: Children and Youth CFM Pre-Meeting

The children and youth discussion group summarized the overall strengths of the CSS DRAFT Plan Requirements as follows:

1. *Our suggestions are heard.* Great examples of age-based plans provided by the state. We feel that someone is listening.
2. *Plan structure.* The concept of serving a small group well helps to inform and create the broader vision and to serve everyone well.
3. *Flexibility to* combine enrolled member services and system capacity planning.
4. *Guidelines are inclusive and comprehensive*.

2. Transition-Age Youth (16 – 25)

Tina Wooton facilitated the transition-age youth discussion which focused on Section V of the CSS DRAFT Plan Requirements, and concerns and major strengths of the overall CSS DRAFT Plan Requirements.

Section V – System Transformation/Capacity Funding

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- Structural Strategies, bullet 1**:** specifies seamless links with both the children and youth mental health system and the adult mental health system, as appropriate. Transfer out of a transition-age program should be negotiated with the client and not occur until s/he feels connected with the adult mental health system or successfully moves out of the mental health system altogether.
- Add language about exit strategies to bullet 1.
- Structural Strategies, bullet 2: add “transition-age youth can be staff, who are hired and trained.” The staffing for the transition process should be peer-run. Transition-age youth should be part of the pool for hiring and training as staff. Transition-age youth should receive equal treatment and equal pay.

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- Support Strategies, bullet 4: clarify “Recreation.” Add social activities to this bullet to read “recreation and social activities.” Ensure that transition-age youth are part of the planning and development of activities. Recreation is listed as a service strategy and it needs support and involvement of the youth in the development of the activities.
- Service Strategies, bullet 5: add comparable pay and benefits to supportive employment.

- Service Strategies, bullet 8: trauma-informed services: add peer-run services and services for young men, and gays, lesbians, bisexual and transgender people (GLBT).
- Service Strategies, bullet 9: add “train-the-trainer programs to develop peer support and training” to youth and family-run services.
- Service Strategies, bullet 10: add peer support to crisis services. When a youth is in crisis, it is important to have the option to be with someone who has shared the experience.

Concerns with the Overall CSS DRAFT Plan Requirements: Transition-Age Youth CFM Pre-Meeting

The transition-age youth group discussed overall concerns:

1. Add “trained peer support” in all services listed.
2. MHSA funds should not be used for involuntary services.
3. Care needs to be taken not to tie the hands of caregivers who are responsible for youth under 18 years of age.

Strengths of the Overall CSS DRAFT Plan Requirements: Transition-Age Youth CFM Pre-Meeting

The transition-age youth group discussed strengths regarding the CSS DRAFT Plan Requirements and process:

1. Having a transition-age youth section in the CSS DRAFT Plan Requirements.
2. Including supported housing.
3. Use of Personal Service Coordinator rather than a case manager.
4. Supportive employment including development of job options for young people on page 22, bullet 5.
5. Trauma-informed services, on page 22, bullet 8.
6. Youth and family-run services including peer support, self-help groups and mentoring programs on page 22, bullet 9.
7. Services to assist families in supporting youth during this period, on page 22, bullet 10.

3. Adults

Sharon Kuehn, facilitator, described two potential tasks for the adult age-based discussion group: to discuss position papers of the three organizations, only two of which are relevant to adults, and to clearly identify three to five major concerns and

strengths to present to the afternoon workgroup session. The adult group spent its time identifying and prioritizing concerns.

Concerns about the CSS DRAFT Plan Requirements: Adult CFM Pre-Meeting

Voluntary Services Only

- Instead of using force and focusing on law enforcement, use recreation departments. Why put money into training sheriffs when people are being treated really badly?
- Section V describes some wonderful programs, but there is nothing explicit about these programs being voluntary. It is implicit, but needs to be explicit.
- All mention of involuntary services must be removed. This is a complete betrayal of the intent of MHSA and the people who worked to pass it. There are other funds for involuntary services; using MHSA funds would supplant them, which is not legal and which we will fight if we need to.
- The community wants to prevent suicide and help the homeless, but clients need more voluntary services.
- When people are in crisis they end up being hospitalized using Section 5150. It would be better to make it easier for them to access voluntary services and to provide them somewhere to stay while going through the crisis, some form of respite center.
- Many participants do not want involuntary services to be paid for by MHSA. However, if a county has a mental health court, these clients should have access to the same voluntary services as mandated services. If a client can choose to use a drop-in center, courts should be able to make this available to those involved in the mental health court.
- Stakeholders need more education about the criminal justice system and those in criminal justice system need more education about mental health.

Personal Empowerment Outcomes

- Personal empowerment outcomes measures are necessary: they are identified in the philosophy, but missing in the details in Section V. Include wellness, recovery and empowerment measures as well as community issues. The CSS DRAFT Plan Requirements seem to be written in stone, not draft: will feedback be incorporated if it requires major changes to the document and reconceptualizing of the requirements?
- Community issues are highlighted because the entire population of California passed the proposition so it is important to make sure those interests are heard and addressed. MHSA must address both the community issues and the empowerment measures. Both are needed.
- A.C.T. is mentioned instead of AB 2034 in Section V, although they are different programs. AB 2034 is more client-value-driven than A.C.T.
- Instead of saying “value-driven, evidence-based clinical services, use “client-value-driven.” MHSA should be set around what the individual client values, rather than what others think the clients need. There is evidence-based practice on this issue.

- Personal care assistants would be transformational for mental health clients, not for other disabled communities. Services should be self-directed as proposed by SAMHSA.

Requirements vs. Guidelines Clarification

- Are these really requirements? What happens if they are not met?
- Quality improvement is missing. It is mentioned explicitly only in the Prevention and Early Intervention component. It is implicit in the mention of annual updates. MHSA will need to continually evaluate progress and needs to state it explicitly.
- There need to be accountability standards.
- Stakeholders need to have a role throughout the process. What will ensure that counties are responsive and engage stakeholder input?
- Steering committees for MHSA planning at the county level are often really large. In our county, it has about 20 people, building on what the Mental Health Board has done so far. Half of the budget committee is clients and family members. Our county has assured a wide range of participation while limiting the size to increase effectiveness.
- We need an accounting of where we are so we know where we are going.

Collaborations

- Stress collaboration between services. County mental health systems and other agencies need to work together.
- Stress education for families, especially among Latinos, as to what they can expect about the illness' progress and what they can do to help.
- Mental health and alcohol and other drug programs need to talk. Get over the turf war.

24/7 Access Issues

- We need a mobile evaluation team 24/7.
- The 24/7 set up is important for clients and family members; will we receive a phone call in a few minutes any time of the day or night?

Housing Issues

- Add stable affordable housing.
- Section V, page 37: add affordable permanent housing to support services.

Other Concerns

- Respite usually refers to caregivers. However, respite is also important for clients who can go to a congregate living situation before they are in a crisis.
- Maintaining is a problem for people who go through crises.
- If clients go to work and do not succeed, SSI will not make them wait on a waiting list.
- The whole document is unwieldy and should be brought down to scale.

- Make sure rural areas and people in focal groups are heard. Make sure their needs are met. Allow community-based organizations to respond to requirements in addition to county mental health systems.
- Need an anti-stigma and anti-discrimination campaign that includes advertisement on bus lines to eliminate stigma.
- Enrollment: the practice has been in AB 2034. There needs to be a separation between administrative requirements for counties from the experience of the client.
- Safety on the streets especially for women.

Client and Family Member Questions and Comments

CFM Comment: Changes in Medicare will undermine many provisions in the MHSA.
DMH Response: Medicare changes will have profound effects. We are very concerned. When Congress enacted Medicare Part D prescription benefits, it did not take mental health into account. The Department's Medi-Cal unit is very concerned.

CFM Comment: When are we going to get together to advocate for change to the federal guidelines?

CFM Comment: Advocates are working on it now.

CFM Question: Is there supposed to be oversight for counties, like there is for state? They need an oversight committee.
DMH Response: There is nothing specific in the MHSA about what will happen at the local level. The plan requires review by the community. The county must show that they did what they said they would do in their plan-to-plan. Accountability will be in the purview of the state oversight committee. If people have better ideas, these would be appreciated at this time.

CFM Comment: Require an oversight committee at the local level to review the plan and look at statistics.

Summary of Major Concerns: Adult CFM Pre-Meeting

After this general listing, the adult discussion group consolidated its list of major concerns into a smaller priority list:

1. *Voluntary services only.* Involuntary services are antithetical to the MHSA's vision and would be a betrayal of those who worked for its passage.
2. *Requirements vs. guidelines.* How strongly will the state enforce them? Will the requirements have teeth and how will DMH assure the counties follow them? Include effective quality improvement, including learning from our failures.
3. *Personal empowerment outcomes.* Issues are currently couched in terms of community issues. Add outcomes related to personal quality of life, etc. This will

change the focus of the requirements. How will DMH respond to such a conceptual change? Will they be able to make this part of the requirements?
4. *Housing.* Add affordable permanent and independent housing to Section V.
5. *24/7 access to services*. Mobile evaluation teams, phone response, and access to voluntary services in a crisis.
6. *Respite/alternatives for clients and family members*. Alternatives to psychiatric emergencies would mean people could get help in a crisis without breaking down every aspect of their life.

4. Older Adults

Daphne Shaw facilitated the older adult group discussion, which addressed the major concerns and strengths of the CSS DRAFT Plan Requirements and the overall process.

Summary of Concerns about the CSS DRAFT Plan Requirements: Older Adult Pre-Meeting

The older adults discussion group developed a list of concerns about the CSS DRAFT Plan Requirements:

Older Adult Focus
- Current research needs to be included.
- Counties, clients and family members need education about older adult services.
- There is more stigma for older adults coming into systems.
- Need for earlier diagnosis for adults.
- Need staff who can do assessments for older adults.
- Outcomes need to be clarified as they relate to older adults, including stabilization and staying in the community.
- Define resilience and recovery for older adults: “better quality of life.”
- Forms should be easy to read for older adults.
- Impact of Medicare Part D on accessibility to medication.

Housing
- Will older adults be shifted to Skilled Nursing Facilities (SNF) as their physical health needs emerge, where mental health issues are not well addressed?
- Need case managers to help clients in board and care homes understand how they can stay in housing.
- Housing is a huge issue.
- Need rewards for high quality board and care facilities.
- Need housing task force.

Training and Advocacy
- Older adults must organize themselves and speak out.
- Add peer counseling training for older adults.

- Need training for families to help adults' children have access to supports in community, younger and earlier.
- Train mental health clients to work in the field.

Transition-Age Adults

- Three groups really exist:
  - Older adults currently in the mental health system as adults.
  - Older adults new to the mental health system as older adults.
  - Transition-age adults.
- Pay attention to transition-age adults.
- Requirement for older adults and transition-age adults needs to be demonstrated.

Other

- Infrastructure for older adults is missing.
- Need position paper or master plan on older adults.

Summary of Strengths of the CSS DRAFT Plan Requirements and/or MHSA Process

The older adults discussion group developed a list of strengths of the CSS DRAFT Plan Requirements and the stakeholder process:

- There is an older adult section. This is very important, and a big chance to change.
- Ability to make a new plan for older adults in counties.
- Growing numbers of older adults.
- Older adults will have problems they did not have as younger people.
- Early intervention.
- Outreach.
- Use existing services in communities to reach out to older adults (Meals on Wheels, etc.)
- Incorporate Older Adult Demonstration Project outcomes into CSS.
- Older Adult Framework from county mental health directors has materials available for use.
- Older adults fall in "underserved" and "unserved" groups.
- Must specifically address older adults in county plans.

III. Workgroup on CSS DRAFT Plan Requirements Sections V, VI, VII and IX (1:00 – 4:00 p.m.)

One hundred fifty (150) stakeholders participated in the workgroup session, Part II on Sections V, VI, VII and IX of the CSS DRAFT Plan Requirements on March 23, 2005, from 1:00 – 4:00 p.m. This was the second in a series of three workgroup sessions on the CSS DRAFT Plan Requirements.

A. Age-Based Group Discussions

Participants started the afternoon workgroup session by going directly to the age-based discussion group they had self-selected at the previous age workgroup on March 7, 2005: children and youth, transition-age youth (16 – 25), adults and older adults. Participants were asked to sit at tables in their discussions to ensure that each table had representation of multiple perspectives: clients, family members, community-based organization staff, and county mental health staff. DMH staff were available to answer questions and clarify issues. Each table group with the age-based groups worked on similar activities to provide input on the CSS DRAFT Plan Requirements. All of the age-based groups worked on two tasks: 1) generating responses to a set of questions focused on each of the four sections (V, VI, VII and IX); and 2) identifying overall major concerns and strengths of the CSS DRAFT Plan Requirements document.

Each of the age-based groups began with a brief summary of the discussions at the client and family member pre-meeting, presented by the client and family member facilitators.

The first task was organized, section by section, to address the following questions:

Section V - System Transformation/Capacity Funding

- *Do you feel that the strategies listed in Section V pages 19-27 (Structural Strategies, Service Strategies and Support Strategies) will help change the system to be more culturally competent, client and family driven and wellness/recovery/resiliency oriented?*
- *For your age group, what, if anything, would you add to the list of System Transformation/Capacity strategies that are found on pages 19 through 27?*
- *Are there any strategies in that section that you would eliminate or change? If you want to change something, please give us revised wording.*

Section VI – Assessing Capacity

- *What information do we need to know about a county's current programs and staffing in order to judge whether or not they have the capacity to implement their plan?*
- *Does this section get at this information? If not, what should we be asking for?*

Section VII – Work Plan

- *Are there things you would definitely like to see in county work plans that we have not asked for on pages 29-31?*
- *Have we asked for too much detail? Do you have any suggestions for improving the requested responses on these pages? Should we take out or change any of the requested responses?*

Section IX – Local Review and Public Hearing

- *Should DMH give counties more guidance about what kinds of outreach they are expecting counties and/or Mental Health Boards or Commissions to do to insure a meaningful public hearing that will reach all stakeholders, including all ethnic groups and clients and family members of both served and unserved populations? What strategies would you suggest DMH include in these Plan requirements to do this?*

1. Children and Youth

Grace Boda, Pacific Health Consulting Group, facilitated the children and youth discussion group, with support from Pat Jordan.

Section V – System Transformation/Capacity Funding

Structural Strategies

- Pages 19-20: wraparound: add bullet for Welfare and Institutions Code 5850 as a core structural strategy. Expand menu of options. Add paragraph on evidence-based practice, best practices as dimension of transformative strategy.
- Direct mental health services cannot meet total need. Part of capacity should be less direct service and more consultation, especially in schools.

Service Strategies

- Page 19: "Strategies for families": revise to emphasize service to whole family and parent or sibling who may need services for mental health, alcohol and other drugs, other health and social services.
- Crisis services has a good list, but those answering 24 hour crisis lines should have more direct knowledge of clients.
- Trauma-informed services: include young men as well as young women and sexual as well as physical or domestic violence.
- Youth and family-run services: provide more availability of choices for youth in foster and group care, particularly in recreation.

Education Strategies

- Change the negative view of mental health through education on stigma to all cultural backgrounds.
- Successful living classes need funds.

- Supportive educational services: include vocational on-the-job as well as formal education and integration with Individualized Education Plans, Individual Service Plans, and Individualized Transition Plans.
- Expand vision of family and caregivers' education to address broad issues involved in raising a child with emotional disorders or psychiatric disability: mental health, IEPs, parenting strategies, etc. Recommend UACC's "EES (Educate, Equip, Support): Building Hope" model of caregiving. Expand to include kinship caregivers.

Support Strategies

- Use a specific definition of mentoring: is it peer-to-peer or adult-to-youth?
- Add social skills supports.
- Outreach and screening: include broad range of training specific to the client; add youth and family advocates.
- Provide more support for faith-based approaches.
- Add in-home services and periodic, structured training for all caregivers and providers, specific to the needs of the population served.
- Allow funding for interpreters trained for mental health services.
- Transition-age supportive housing: ensure housing specifically to meet the needs of youth in the juvenile justice system and transition-age youth in recovery for substance abuse issues.
- Service planning: add legal advice and legal representation.
- Services to assist families: include transportation, day care, interpretation, access to services, choice of time and location of services.

Client and Family Strategies

- Family-focused: what if the youth does not have family? Involve the youth more.
- Build in more language and philosophy of engaging and partnering with children.
- Emphasize positive rapport between providers and client and family.
- Child and family teams: add caregivers to definition of family.
- Single service plan: expand family definition to cover caregivers.
- All service providers must be educated to listen and be responsive to the child and family.

Out-of-Home Placement Issues

- On-site services in juvenile or emergency shelter. Use special caution to ensure non-supplantation clause is adhered to strictly.
- Transformation care: intensive services available sooner for families before out-of-home placement.
- More support for foster children transitioning between placements and services.
- Ensure services to foster, kinship, guardianship and adoptive homes. On-site services need to include support to families and caregivers at all levels of out-of-home or school placements. Ensure family advocates and youth mentors are provided to all levels of placements.

Service Integration

- Integrate mental health services with substance abuse services.
- Emphasize school-based, childcare services.
- Add integrated service teams to children's section (from transition-age youth section).
- Mandate stronger, more defined role for family partnerships.

Assessment

- Integrated assessment: is there another document better than DSM-IVR to use for cultural formulation?
- If enough money were available and fidelity to the plan requirements occurs, desired results could be achieved.

Evidence-Based Practice

- Need funding and staff to ensure collection of evidence and assessment of outcomes measures.
- Define "evidence-based" by client and family and by the industry.

Other

- The operational definitions of resiliency, wellness and recovery need review and modification. They are too skewed toward role of family. The language conveys fault-finding and blaming. Comments on child and family participation as key are positive.
- DMH should identify children with severe mental/medically-based illnesses that are reoccurring (e.g., depressive, bipolar).
- Incorporate recent recommendations for wording from Foster Youth Subcommittee.

Section VI – Assessing Capacity

Recruitment, Retention and Training

- Address staffing shortages and recruitment issues by developing stipend programs to link potential mental health workers with training programs.
- Ask counties about current trained skill sets and the need for retraining.
- Ask counties about current and anticipated caseloads.
- How will the county reduce or eliminate salary disparities within countywide service system (county and contracts)?
- Add ability to utilize new providers as well as credentialing for new providers.
- Recruitment and retention of qualified staff strategy: compensate training and related supports for staff.
- Client and family training.
- Page 29, (4): provide list of specific barriers such as need to recruit and retain staff at each function level listed.
- Need to match demographics of the community served.

Client and Family Member Staffing

- Page 28, (2)(a)(5): staff should be able to identify as a client or family member.
- Add employment of clients and family members as staff (target as a job class).
- Use family-friendly language.

Cultural Competence

- Page 28, (2)(b): add proficiency with culture, not just language, and add cultures such as gay, lesbian, religion, etc.
- Assess cultural competency plan and compliance with plans vs. needs.
- Page 33: Staffing Matrix: add ethnicity and language skills, gender and sexual orientation.
- Chart does not show the bilingual capacity in relationship to the specific position.
- Page 29, (4): barriers for culturally and linguistically competent staff: e.g., staffing shortage of Spanish speaking staff and child psychiatrists.

Community-Based Capacity

- Ask about the relationship and linkage with private provider network, assessing strengths, where applicable. This will be more difficult in small counties.
- Increase emphasis on community-based programs.
- The system capacity currently does not go beyond the mental health department. Give counties the opportunity to address capacity in a broader, community-based way.

Effectiveness and Accountability

- Require counties to provide historical information regarding their ability to implement innovative and collaborative programming with evidence-based practice in a culturally appropriate and effective manner.
- Page 29, (4): paint a more comprehensive picture of county's ability to accomplish effective implementation.
- Ask for current penetration rate and expected need as well as gaps.

Workloads and Waiting Lists

- Workloads of current staff.
- Current vacancy rates in existing programs (both staff and clients) and current length of time to access needs.

Other

- Page 29: make explicit for county and contract employees.
- Add "other" category on chart to show positions not listed, such as physician assistant.

Section VII – Work Plan

Out-of-Home Issues

- Ask about how many children are in foster care.
- Ask how services will be provided to children who live in out-of-home placements in other counties.
- Ask how children from other counties living in our county may be served.
- The situation for individuals living out-of-county is a large problem statewide, which will not be adequately addressed just by describing it. DMH should put forth a method to resolve this issue on a statewide basis.
- Include former foster youth.

Technical Issues for Completing Work

- Exhibit 4 is unclear.
- Page 31: 2(c): change implementation dates to timelines.
- It will be difficult for small counties with old data management systems to answer all these questions.
- Provide better description of underserved and unserved. Give examples of children of adult clients or children 0-5. Move iii to d(i) community issue.
- Allow flexibility for actual implementation where plans always have to adjust to real time events: the level of concrete detail is a big concern. See Exhibit 3.

Accountability and Assessment

- Provide narrative regarding the program design for how data (evidence) will be measured, collected, and integrated into existing service.
- If expanding programs, county needs to show success of current programs. If beginning new program, list how success will be measured using industry defined outcome measures.

Law Enforcement

- Law enforcement education should be provided on mental health issues.
- Page 31: 2.iii.3: identifies law enforcement as a stakeholder. What about identifying schools in children's section?

Other

- What kind of crisis services will be provided?
- Need to respond to specifics listed in Sections V and VI.

Section IX – Local Review and Public Hearing

Support for Client, Family Member and Community Participation

- There is much concern about how stakeholders will be able to respond to a document which is clearly difficult to understand at best. Needs to be "interpreted" and circulated in a way that is truly accessible by all stakeholders, especially the

underserved and unserved, including accessible and friendly to youth, adults without access to computer or who are not computer-savvy.
- Require training for stakeholder groups (foster youth, adults, juvenile justice), in order to assist them in understanding the county draft plan.
- Ask for specific documentation of stakeholder feedback and major recommendations of needs that are not met.
- Include members from the underserved and unserved population at all local and public hearings.
- Include community leaders, both appointed and natural, in planning.
- Involve youth, family and caregivers in design on meeting.
- Provide adequate support to attend, incentives such as transportation, food, childcare, etc.

Outreach Methods and Meeting Mechanics
- What did the county do as far as public information in order to get information about meetings to the underserved or unaware public, using schools, newspapers, radio, etc.
- Public posting of recommendations, responses and timelines.
- Use public notices in community-specific methods.
- Provide more guidance. There is a presumption that if we follow our adopted plan to plan and do public review, we will have met the requirements. If more is required, it needs to be clearly stated.
- Ensure plan is written to provide outreach at the location of meetings already occurring for underserved or unserved populations.
- Use town hall style meetings.
- Use multiple locations and times.

Accountability
- Need more detail. Need prescriptive plan which protects the fidelity of the plan developed by applicant county, not subject to significant change by Mental Health Board or Board of Supervisors.
- Require that counties keep the correspondence on record and make available for review. Add DMH appeal process and office (name and phone number, etc.)
- Mandate list of stakeholders to ensure counties are reaching out.

Summary of Major Concerns about the CSS DRAFT Plan Requirements: Children and Youth

Insufficient Focus on Children and Families
- Current model is adult-focused and the approach to children is forced into that perspective; requirements need to reflect more of the essence of children and families.

- Resiliency, recovery and wellness focus is adult-oriented: philosophy and concepts need to be appropriate for children and youth. Create a workgroup of children and youth advocates and specialists to help with this.
- Inadequate youth representation, including youth in residential treatment and foster care.
- Does not include education and training of everyone, including family, clients, law enforcement.
- It is not written in family-friendly language; it needs to be made relevant to children.
- Severe emotional disturbance language is not friendly to children with severe mental illness.
- Does not address or reflect family focus, strength-based focus for family (emphasis on strengths vs. weakness).
- Children's services are limited. The document needs specifics for differing age groups, more on 0-5 population specifically.

Accountability and Funding Concerns

- Allow services to start as the other parts of the plan are rolled out.
- Draft does not deal with or address transformation in the large fiscal context of loss of AB 3632 funding, EPSDT audit paybacks, Medi-Cal regulations and loss of CSOC funding, even though the MHSA calls for its inclusion and reinstatement.
- Not enough focus on blending funding.
- Need to provide financial incentives for counties to include internal and external collaboration, including family partnerships, rather than compartmentalizing and creating competition for funding.
- Need accommodations for small counties.

Enrollment Issues

- Adult frame of reference forces children and youth into an enrollee-based system that they are least suited for.
- Does not include or reflect the values and principles of the children's system of care. "Enrollment" approach may reduce current services or system of care. Services should focus on serving populations, not only enrollees.
- The concreteness of enrollment may be confused with or be in conflict with the variability of outreach to and engagement of the underserved.

Other

- Why is wraparound required? Why just this specific model?
- Participants need training to be part of the process.
- Staff development, training, recruitment and retention should be concurrent with CSS plan.
- Workforce development should be concurrent with CSS.

Summary of Strengths of the CSS DRAFT Plan Requirements and/or MHSA Process: Children and Youth

Process Inclusive

- DMH's key stakeholders' process has reflected the involvement of clients, youth and family members. Needs focus and work on county level.
- Family and clients are valued in the process.
- Giving voice and choice to clients and family members.
- Process reflects philosophy of inclusiveness.

Holds Counties Accountable with Fair Balance of Requirements and Creativity

- Makes counties accountable for populations identified.
- Gives counties structure, accountability and direction.
- The concept of an ongoing "treatment plan" for the counties' plans over the next five to ten years – the ability to adjust the plan over time.
- Strikes fair balance between prescription and flexibility.
- Struck a balance between guidelines and framework with examples without being unduly prescriptive.
- Capacity funding is not exclusively tied to the enrollment plan.
- Ongoing ability to adjust plan.

Philosophy

- Attitude of transformation from "business as usual" is encouraging.
- Overall effective leadership. The document is outstanding, clear and consistent with MHSA, California Mental Health Master Plan and President's New Freedom Commission.
- Infuses cultural competency throughout.
- Focus on partnerships, including family/caregiver, and integrated teams.
- Values families and clients.

2. Transition-Age Youth (16 – 25)

Babs Kavanaugh, Pacific Health Consulting Group, facilitated the transition-age youth group, with DMH staff support from Dave Neilsen.

Section V – System Transformation/Capacity Funding

Staffing

- System change will require training for direct care staff. Unless staff are working in a recovery model, clients and staff cannot succeed without training.
- Transition-age youth need to be included as able or willing in training and staffing with full involvement without prejudice, i.e., from line or management staff.

Peer Services and Support
- Add peer-run support.
- Add crisis support by peers.
- Add peer development of activities.

Youth Focus
- Pay particular attention and be sensitive to youth who experience first break (psychosis). Include support for families dealing with first break and education for their friends.
- Add service planning that involves youth.
- Focus on transition-age youth as the author of services, not the family.
- Place a general emphasis on support teams. The CSS DRAFT Plan Requirements mention family-driven instead of youth. Include a sensitivity to youth who may not have family.
- Structures must include full participation in local community of choice.
- Provide school release or community service release for day meetings.
- Hold more meetings outside of normal school and working hours.

Support Services and Strategies
- Add exit strategies from children and youth section.
- Add train-the-trainers.
- Add integrated community-based recreation opportunities.
- Provide community education about stigma.
- Include some strong formal link between children and transition-age youth as well as child welfare, probation and education to ensure all youth are involved.
- Put an emphasis on hands-on experiential assistance over classroom education.
- Make a clearer link to supportive higher education services, such as college groups, housing.
- Include childcare and respite opportunities.
- Include stipends for students, trainees, etc.

Language Needs
- Make language client and family member-friendly.
- Change “enrollment” to “participant” throughout.

Page 19
- Add wraparound services to the language in the transition-age youth section from children and youth section.
- Add to wraparound services: housing, placement or home situation, whether they are parents or have children.
- Add bullet 2 to the transition-age youth section on structural strategies.

Page 20
- Youth-monitored housing programs: monitor to see if services and programs are up-to-date, and allow youth in the program to gain experience and to have a job.

- Bullet 3: single service plan needs to come with dollars and technical assistance.
- Last two bullets: two opinions were 1) no MHSA funding for juvenile camps (locked facilities) and 2) it should continue if the treatment of services is voluntary.

Page 21

- Last three bullets: add wording “client-directed.” Clients sometimes cannot obtain the services they want or need, so clients either have to take whatever services the county has to offer, try to get services in another county or go without. Each county should have a continuum of services for all clients.
- Last bullet: include voucher housing on list.

Page 22

- Service Strategies, bullet 2: identify needs as well as meeting the needs identified.
- Add bullet for respite care.
- Add outcomes that are individually driven and prioritized: youth are empowered to choose for themselves.
- Add how money will be monitored.

Section VI – Assessing Capacity

Data Needs

- Collect census information on how many transition-age youth are in the county, including numbers of transition-age youth in probation, child welfare, special education to assess what percentage of the total transition-age population may need services.
- Baseline assessment and data collection need to be age-specific.
- Ratio of staff should equal ethnic/cultural percentages of transition-age youth.
- Identify contracts and MOUs with other agencies.
- Identify how county reaches out to other community leaders (e.g., by interpreters, services).
- Clarify issue of dedicated vs. shared staff: shared staff are only acceptable in rural areas. Address geographic accessibility for transition-age youth services.
- Ask for an assessment of system capacity that evaluates staffing. It should include caseload data, to understand how many clients and families can be served by the staff who are listed in the inventory.
- Determine if transition-age youth are a standing item with interagency groups, to assure they are not forgotten in interagency planning efforts.
- Page 29, sections 3a and 3b: the word “disparities” needs to be “inequity” or “compare and contrast” between populations. Provide an analysis of the existing community supports and services supports in each community and compare with the needs assessment.

Staff Qualifications

- Identify trained staff.

- Need quality as well as numbers: motivation of staff is critical.
- Clinicians should have knowledge, attitude and skills to help transition-age youth be successful. This is a barrier that should be addressed and should be part of bullet 2 under structural strategies and under “Assessing Capacities.”
- Assess willingness to collaborate.
- Add in human resources section: identification of people who have experience in foster care and juvenile justice system as well as of individuals who have worked successfully with transition-age youth.

Youth Employment
- Youth should become counselors. For example, Los Angeles County is using youth as counselors in a civil service program.
- Embed language that encourages outreach to and hiring of former foster youth. Year 1: develop job description and recruit; Year 2: fill position; Year 3: evaluate and expand.
- Page 28: Section 2a – 2b: add former foster youth to the list and provide training for foster youth to take these jobs.

Assessment Tools
- Create an ongoing, flexible, individualized assessment tool.
- Look at and update policies and procedures.
- Page 28: bullet 2 and 5: add to the transition-age youth section.

Enrollment Issues
- Enrollee services are not appropriate for transition-age youth.
- Do not limit to enrollee-based services.

Access
- Transition-age youth need to be able to come in and out of services at will.
- The services need to be available to all, not just Medi-Cal beneficiaries.

Section VII – Work Plan

Enrollment Issues
- Enrollment has to operate differently with transition-age youth. Emphasize that transition-age youth have a right to choose if they take part in self-directed services or not (i.e., it is voluntary?).
- Do we need to limit to enrollee-based services? Are there other ways to gather data?
- Enrollee-based services limits the number of clients served, but MHSA wants to expand the number of services.
- Break down barriers to enrollment.
- Participant-directed services should replace enrolled member services throughout the document.

- Exhibit 2: enrollee-based system form does not ask for capacity numbers. Sample workplan for transition-age youth: 1) housing, with support; 2) employment; 3) assign a personal services coordinator who really cares and finds solutions.

Assessment and Accountability
- There needs to be alternate screening for transition-age youth, such as tools that evaluate Maslow's hierarchy of needs or life domains.
- Is there a tool for assessment? Should it be standardized or per county?
- Add a tracking system especially for foster youth placed out-of-county or being served out-of-county.
- Add a consequence that ties to their funding amount if a county does not meet implementation dates.

Service Plans
- Indicate how county service plans will dovetail with the statewide outcome system.
- Service plans should be person-centered: specify the baseline for each enrolled client in the service plans.
- Service plans need to be living documents. Things change and plans should be updated when they do, with a legal minimum of every six months.

Other Issues
- Confidentiality is important and CPS-mandated reporting is not funded by MHSA.
- Intensity of services should be the same no matter what county the person lives in.
- Clarify 1(d)3: "Which of the following community issues will be addressed in this program? Describe the situational characteristics of the individuals to be served."

Section IX – Local Review and Public Hearing

Outreach
- Need more specific outreach efforts to reach populations, especially for transition-age youth.
- DMH, through MHSA funding statewide, should pay the counties to hire and train outreach workers who come from the unserved and underserved transition-age youth communities. Make this client-driven outreach.
- Hold different forums all over the county, including youth speakers at school rallies, Internet, PSAs, other media, church presentations, Chambers of Commerce and all public agencies.
- In addition to the county-run workgroups, there should be a tool that can be used in a multitude of settings that focuses on the issues that can be tailored to populations.
- What constituents were reached out to? Show list of stakeholders. Instead of "who circulated to" use "edited by."
- County websites statewide need to use laymen's language. They must be user-friendly.

Meeting and Review Requirements

- Require counties to have more than one public hearing. There should be several smaller hearings at local community-based organizations, such as group homes, older adult centers, community centers.
- Public hearings need to be in the evenings.
- The mandatory county stakeholder task forces must be up and running in all counties. Who follows up with every county to make sure this is happening and who is offering support if it is not? This is a DMH job that is not being done because some counties do not have a county mental health MHSA task force.
- Cite controlling code sections in state law that will be required of each county plan, or design a specific format and requirements for plan review as regulations under MHSA and provide trainings for mental health boards to hold these meetings.

Summary of Major Concerns with the CSS DRAFT Plan Requirements: Transition-Age Youth

The transition-age youth discussion developed an extensive list of key concerns:

Peer and Other Support

- Need a more generalized reference to support and more work to be sure that foster youth and juvenile youth have a support person when transitioning.
- Need to balance in developmental stages choice by youth and legitimate needs and concerns of parents and providers.
- Staff motivation and quality.

Inclusiveness of Process for Transition-Age Youth

- This has not been an inclusive process for transition-age youth in county and state stakeholder task force meetings. There have been issues such as times of meeting (during school); insufficient outreach; no accountability for stakeholder process or non-supplantation.
- Mandate youth and family involvement in county decision-making process, because of historical lack of access; not inclusive enough of youth; youth are outside of power.
- Solicit active participation of youth in planning; do not merely consult them.
- Ensure constituents truly participated and were not just handed a plan to read.
- Language is not client or youth-driven. It sounds like a county plan. If DMH and counties want youth voices and participation, facilitate access and go where youth gather.

Enrollment

- Change emphasis from enrollment to participant-directed services. It is important for transition-age youth to voluntarily participate in services. Services should be guaranteed regardless of ability to pay.
- Enrollee-based services may limit access to services. How can DMH obtain data differently? Small counties may be limited to a handful of clients.

- Enrollment-based services undermine the spirit of the integrated, as you need, seamless response to the larger population. It basically creates isolated populations with barriers to being responsive. At a minimum, have a flexible formula and definition for enrollee.
- Enrollment member issue is too restrictive. This may limit access to services, especially in small counties and serve as a barrier to youth. Slots minimize meeting needs and undermine a seamless system. Participants were concerned about the requirement that a person must be enrolled to receive services. "Participant-directed" or "transition-age youth client-driven" are better terms. There must be a better way of getting the data. More clearly identified flexible enrollment process is important for clients, and/or residents to understand the intention of the enrollment process.

Accountability
- There is not enough emphasis on accountability for transitional services, including housing and vocational training and support.
- Need specific language that includes out-of-home care.
- Outcomes are not driving the plan. It is still service-based.
- Require family and client involvement and responsibility in county decision process.
- Develop one-year plans for things we know (AB 2034 and wraparound) and three-year plans due in one year.

Summary of Major Strengths of the CSS DRAFT Plan Requirements and Stakeholder Process: Transition-Age Youth

The transition-age youth discussion group identified an extensive list of key strengths:

Inclusiveness of Age Groups in Process and in Document
- The fact that transition-age youth have been identified as a separate category of its own and outreach given to bring in transition-age youth participation.
- Tries to be inclusive of language and ethnic communities.
- Identifies diversity in sexuality, spectrum of gender, foster youth living situations, etc.
- Covers all age groups.
- The outreach involved to get the feedback for the CSS DRAFT Plan Requirements has been good.
- It is a detailed and thoughtful process.

Philosophical Underpinnings
- Emphasis on community-based services that focus on wellness, recovery and prevention, as opposed to institutional services.
- Concept of family/client-driven.
- Emphasis on wraparound and other evidence-based programs, but still allows for innovation.
- Training and education component for everyone is recovery-focused.

- More prescriptive than previous plans.
- Challenges the way "we as providers" have looked at mental health and requires providers to work together with recovery as the goal.
- Emphasis on recovery as determined by the individual.

3. Adults

Lisa Canin, Pacific Health Consulting Group, facilitated the adult age-based group, with DMH staff support from Dee Lemonds and Marilynn Bonin.

Stakeholder Questions

Stakeholder Question: Why are we separating the three types of strategies: services, structural and support strategies?
DMH Response: DMH thinks there is a distinction between them, while acknowledging an overlap.

Stakeholder Question: Is there guidance that DMH will only fund one or the other?
DMH Response: Absolutely not. DMH expects to fund multiple strategies.

Section V – System Transformation/Capacity Funding

Housing, Respite and Crisis Care

- Focus on supportive housing is crucial and needs to include affordable, permanent housing.
- Include patients' rights advocacy to help clients deal with stigma in rental market. Advocacy is presently underfunded and needs better training but could expand beyond board and care homes to look at broader community.
- Include respite with peer support.
- Include respite care for clients in crisis. This gives families a break that is not hospitalization, to calm down, remove the client from the stressful situation. Monterey has a residential care system that keeps hospitalization down considerably.
- Page 23: weak on alternatives for institutional treatment. Does not require strategies to provide alternatives to incarceration and institutional settings. Add specifics across age groups.
- Provide for alternatives to hospitals, IMDs, homelessness, i.e., crisis residential (Turning Point Crisis), transitional residential, 28-day programs.
- Provide incentives for board and care operators to provide transitional support and ongoing support for independent living. Oversight must be provided by counties.
- Include safe housing and education on how to keep safe.

Client and Family Focus

- Change "values-driven evidence-based" to "client/individual-value-based" services.

- Remove A.C.T., which is coercive, and put in AB 2034, which is client-driven.
- Have client and family member advisory committees on every organization for feedback and quality control.
- Self-determined client-directed care, as described in the President's New Freedom Commission on Mental Health's report, *Achieving the Promise: Transforming Mental Health Care in America*. The self-directed care used in Florida is an innovative approach.
- Build structural capacity with focus on family members and citizen client advocates, as liaisons to other parts of community and government.
- Beef up the Mental Health Board with additional support and build up client networks. Bring family and clients into oversight of the counties.
- It is good that DMH mandates client involvement. Next stakeholders need to know this will happen and how counties will be held accountable to it.
- Integrate service with family and client organizations, i.e., education services for family members and peers.
- Strategies need to address explicitly what quality of life outcomes the service is designed to address.

Structural Strategies

- Page 20, Bullet 5: include regional centers.
- Add "increase advertising on mental illness to other agencies to enhance integrated services."
- Talk about exit strategies, which are key to recovery: gainful activity and adult education for job skills; create incentives to get work, increase literacy skills, computer education, life skills training.
- What is available for those who are far from being able to be in the job market?
- Exit is scary to family members. Graduation may be a better term.
- Collaborate with existing community supports, such as faith communities and housing experts.
- Provide more mental health education for police and sheriffs.
- Use similar structural strategies, defined with same language, across all age groups with additional sentences to add specifics per age group if necessary.

Service Strategies

- More focus on peer supportive services and client and family-run services.
- Page 20, Bullet 3: add clients and family members as a part of the team to A.C.T.
- Add "professionals are trained in physical and developmental disabilities" to A.C.T. or assessment teams.
- Increase community resource centers.
- Add strategy to provide alternatives to institutionalization, e.g., include crisis residential treatment, transitional residential treatment, supported housing.
- Access to all FDA-approved medication for all clients.

Voluntary Services Only

- Use more explicit inclusion of the phrase “voluntary services” throughout this section.
- Page 27: delete involuntary services; they are incompatible with MHSA funding.
- Create entry points that are not jail or hospitals: recreation, barbers, education.
- When the advocates go to 5150 hearings, they should do a good job, not just be warm bodies.
- Need more time to fully discuss this very important section.

Support Strategies

- Page 24: add “both/and” to on-site services in faith-based communities.
- More complementary services: body/mind and holistic.
- Talking therapies, acupuncture, massage, spiritual healing should be additions, not replacements.
- Personal attendants for mental health clients, from In-Home Supportive Services (IHSS), makes it 24/7, and brings money back to mental health client.
- Psychiatric and medical advance directives.

Education and Training

- Use existing active groups to provide classes for educating the community on issues of mental illness.
- Section V does not specify the nature of education; it is generic. Client and family groups should be prioritized to this education. Nutrition education, education on medication.
- Clarify supportive education.
- Include education around issues of obesity, health issues, homeless eating disorders, money management, dual diagnosis, chemical dependency issues, and Medi-Cal. Cross-reference with charts.

Accountability, Assessment and Identification

- Include assessment of existing programs.
- The Mental Health Board oversight committee should include consumers and professional staff.
- Compare what the county already has relative to the MHSA vision.
- Page 19, paragraph 2, last sentence: counties should be required to explain how whatever they propose to do is consistent with MHSA.

Evidence-Based Practices

- Need to use evidence-based practices.
- Evidence-based requirement is too limited.
- AB 2034 is not evidence-based, but has excellent outcomes.

Community-Based Services and Integration

- Identify more specifically other groups of adults who would be more responsive to mental health services in primary care settings.

- Provide a broader definition of “primary care clinics” that includes county, community-based providers and physicians.
- Section does not explicitly say MHSA is developing a system based on community-based care. Need more mention of continuity of care.

Transition-Age Adults

- Age group 55-59 may also fit into adult section. This needs to be addressed in both adult and older adult sections “to assure a smooth transition.”
- Adult section needs to acknowledge that, just like with youth, there is a need to recognize the concept of “transition-age adult.”

Other

- Top-down decision-making needs to change in counties and at state level.
- Do not employ fail-first strategies.

Section VI – Assessing Capacity

Stakeholder Questions

Stakeholder Question: How does workforce development fit into the whole picture?
DMH Response: There is staffing capacity: how many do you think you will need? Staffing is the start of system capacity. Staffing capacity should feed into the education and training component: what will it take to have staff who are capable of providing the services?

Stakeholder Question: What about having a section on geographical capacity? Small counties have numerous mountains to cross that make delivery of services almost impossible. We need to place staff closer to clients.
DMH Response: These are the kinds of comments we are looking for.

Stakeholder Question: For the section on current staffing capacity: is the county supposed to look at other providers outside the mental health system and assess potential contracts? Is this mentioned in any other section?
DMH Response: It does not appear elsewhere. If it is not in this section, add it to your list of suggested changes.

Data Collection/Additional Data Needs

- Add technical innovations that assist counties in staffing capacities, such as telemedicine and mobile clinics. There is one concern that these methods are impersonal, not a preferred method. Use support teams with them.
- Add geographic accessibility.
- Ask how long waiting lists are.
- Ask about potential community-based organizations to be contracted with to increase capacity.

- Assess capacity to employ staff because of working conditions and salaries in areas, which affect ability to recruit.
- In large counties, staffing should be enumerated by site and organization.
- Ask about educational degree of providers working with temporary credentials.

Client and Family Member Staffing

- Ask about the number of self-help programs in the county and how well paid the clients are.
- Include self-help providers, client-run services providers and trained peer counselors.
- Ask how many clients and family members are hired now and how many could be hired in the Mental Health Department and other collaborating agencies.
- Exhibit 1: add columns for gender, diversity, language. Change the order so that client is first.
- Best to leave to the county commissions to flush out staffing needs. There are not enough practitioners presently to serve clients. Counties will need to build capacity, place emphasis on bringing clients and family members into this expansion of paid workers.

Additional Staff Qualifications

- Add a way to determine professional expertise, i.e., individuals who have special expertise in co-occurring conditions, such as developmental disabilities. Add developmental disabilities expertise to chart.
- Add providers who are trained in co-occurring disorders.
- How are counties going to transform their workforce to ensure that staffing needs are identified, based on capacity of staff to provide rehabilitation and recovery-based services? This requires looking at ability, not discipline. Traditionally trained disciplines have a less than positive track record in providing recovery-oriented services.
- Where is the assessment of recovery and rehabilitation capacity of staff? This should be the first item: describe strengths, barriers to delivery of recovery and/or rehabilitation-oriented quality of life outcomes services.
- Add an item about assessing capacity to enhance natural support systems serving cultural groups and ethnic communities, supporting development of culturally congruent services.

Professional and Alternative Staffing

- The list of job categories does not line up well with the list of strategies described in the plan, such as rehab specialists, housing specialists, job developers, etc.
- Add the non-clinically trained staff positions, such as mental health advocates.
- Include physicians, nurse practitioners, physician assistants, educational counselors, vocational rehabilitation, parent educators, holistic providers (herbalists, massage, faith healers, acupuncturists, medicine “men”), case managers and outreach workers (and their cultural competence)
- Increase use of interns and nurse practitioners.

Other

- The capacity section should address the capacity in the counties to perform functions addressed in Section V.
- Existing staff has nothing to do with getting or attracting new staff.
- Ask who on staff is responsible to complete Exhibit 1, Current Staffing Capacity. Ask how it is completed.
- Current staffing capacity: billing infrastructure capacity. Assess to ensure efficient processing of claims, payor collections, etc.
- Evaluate the ability to leverage additional entities to add additional funds to the MHSA and fulfill the MHSA mission. County should develop a road map of working with other entities and evaluating collaborative outcomes.
- System capacity increase should have no restrictions for eligible clients.
- Increase the number of providers.

Section VII – Work Plan

Stakeholder Questions and Comments

Stakeholder Question: Is it accurate that counties cannot change the language for the plan-to-plan?
DMH Response: Correct.

Stakeholder Comment: Our county has 170 people in IMDs and ten more migrants this month. Service utilization depends on what people want; they move to other counties depending on services.
DMH Response: DMH is looking to the milestones tied to the county plan's budget. DMH cannot evaluate based on outcomes, but on what programs the county has agreed to implement.

Accountability

- Be explicit about how often "periodic progress reports will be required": quarterly, semi-annually, annually?
- Ask for annual assessment by clients, family and support network regarding the degree to which the plan is responsive to their input.
- Empower local clients and family members to make counties accountable to input.

Outcomes

- Ask for more specificity in goals and achievable outcomes.
- Make sure plan includes outcomes like reductions in homelessness, jail time and hospitalization.
- Any program expansion or new program proposals must identify what client quality of life outcomes will be addressed and how effectiveness will be evaluated. Without accountability to client outcomes, transformation will not occur.
- Make clear the counties' commitments to recovery.

Voluntary Services Only

- Refer to Page 27, the community self-help groups, wellness, recovery and reduction of involuntary services. Stick to spirit of AB 2034. Funds for hospitalization should come from existing funding. Reduce need for IMDs. There is concern that MHSA money not be drained for long-term hospitalization. It should be used instead for community integration, wellness and recovery. Funding should transform the system, rather than pay for involuntary old style treatment.
- While there is a lot of sentiment not to use funding for involuntary services, some family members do not want to rule out funding for involuntary services to deal with the most ill.
- A client says she was homeless eight times and had to go to extremes to get help. If voluntary services were available on demand, clients would not have to resort to more extremes.

Data Needs

- Page 30, Response (1)(d)(vi) and Page 31, Response (2)(b)(v): how does the data address ethnic disparity issues?
- Page 30: Response (1)(d)(iv): ask counties to describe the service strategy and include a narrative description of how people will be enrolled, in addition to the checklist.
- Ask how these changes will affect the system.
- Ask how many people will be served, within each age group.
- Ask in what ways clients are moved in and out of services.
- Ask how the county will work with families and clients in achieving their defined goals.
- Ask for statement of projected capacity.
- Ask for progress on individual treatment plans.

Other

- The time frame piece is not clear.
- Long range planning should reflect more than three years.

Section IX – Local Review and Public Hearing

Stakeholder Question: Does the county Mental Health Board have to approve plan?
DMH Response: No approval from the local mental health board/commission is needed; their review is required, however.

Methods of Review

- Is it acceptable for a county to hold public hearings by supervisorial district, not countywide?
- Require transcripts of hearings.
- Make explicit that all comments, both written during the thirty-day review and offered during any public hearings, must be addressed and included in the report to DMH.

Accountability

- Page 31, Response (3): DMH should clarify the guidelines for Mental Health Board revisions. What can the boards revise based on public comment and public hearings? Provide clarification.
- Mandate annual review by client and family member advisory committees to the degree to which annual goals have been met.
- Ongoing accountability of the county to its Mental Health Board or stakeholders, such as a county oversight committee to watch if the grants are implemented properly, like a quality improvement committee.

Support Client and Family Member and Community Participation

- Some counties are so scattered that money must be available to ensure clients and others can attend meetings.
- Ensure grassroots decision-making. There is too much top-down decision-making.

Feedback to and from DMH

- DMH must oversee county plans.
- Allow for reporting of comments and complaints about county plan at state level.

Key Concerns: Adults

Voluntary Services Only

- Include requiring the development of alternatives to institutional settings (e.g., hospitals, IMDs, jail).
- System capacity funds (not enrolled members) can only be used to develop community-based voluntary services to minimize or eliminate involuntary services.
- There has not been any specific statement prohibiting involuntary treatment funding use.
- No funding for involuntary services under MHSA.

Personal Empowerment Outcomes/Transformation and CFM involvement

- Emphasize exit strategies, self-help groups to help clients in IMDs get back out; allow client-run programs in to do this, to promote wellness and recovery, help people get out of involuntary services.
- Document is not sufficiently transformational in that it does not operationalize "transformation." Include measurement and accountability for client level outcomes such as quality of life.
- County cost-of-living and salaries will affect staff ability and client quality of life and dignity.
- Not very transformative: mirrors existing system, especially given that there is very little about client-run services.
- Concerned that monies will go to maintain the present county mental health systems. DMH needs to show teeth to ensure more client and family involvement. Concerned about old language about community standards in the MHSA state plan.

- Concerned that the CSS DRAFT Plan Requirements will be the starting point for counties and they will not develop a much more expansive stakeholder vision of what the MHSA could be to meet the needs of their community.

Requirements, Guidelines, Recommendations and Accountability

- Continual capacity building over the years and accountability by the county and a county oversight committee not adequately addressed.
- Overcomplicated by being too prescriptive.
- What does "underserved" mean?
- Document is as good as it operationalizes the MHSA, but specifics should be expanded upon to identify what is a recommendation, a requirement and a guideline.
- Underserved (ethnic) communities, clients and family members are supposed to be at the center of this system transformation. Yet they are not empowered with appropriate tools to do so. If counties are not involving them in significant ways, clients and family members should be able to inform DMH. Have a mechanism to do so. This will lead to creating mental health services at the local level that really meet local needs.
- Stakeholders need training and ongoing support.
- Oversight and accountability for counties.

Enrollment Issues

- Enrolled members should not exclude the currently underserved or unserved. 50% funding for the new enrollment concept may be over-funded and existing clients in the system are likely to be underfunded.
- Need a better balance between serving enrolled participants and system capacity needs (those who are underserved or unserved).

Housing

- Provide a better explanation of supportive housing and a consistent focus on permanent, affordable housing. See Corporation for Supportive Housing recommendations (www.csh.org).
- Add permanent housing plans into the document.

System Capacity

- Assessing capacity must include assessment of the following: 1) psycho-social rehabilitation (PSR) recovery-oriented competencies of staff; 2) ability to enhance naturally occurring support services serving underserved groups; and 3) strengths and barriers of system capacity to provide recovery-oriented services.
- An assessment of system capacity that looks at staff should also include caseload data. Counties need to understand how many clients and family members can be served by the staff who are listed in the inventory.

Other

- Have not emphasized safety and safe behaviors enough in the client's personal life.
- Sets expectations very high.

- Language is too lingo-based, bureaucratese. Simple English, please.
- Failure to get federal matching funds upfront. State needs to leverage federal dollars.

Major Strengths: Adults

Process Inclusive, Collaborative and Well-Communicated
- Involves clients, families and providers in collaboration.
- Involves clients and family in the planning, advocacy and implementation process.
- Good process; needs to happen, thanks.
- DMH has made every effort to keep people informed during this process. The material is generally accessible.
- Communication in the stakeholder process.
- Permission to fund client and family participation.

Philosophy
- Balances the need for biomedicine with socio-environmental concerns in a holistic fashion: self-empowerment, rather than a case to be managed.
- Creates funding for alternative approaches to hospitalization.
- Funds systematic transformation.
- Sections IV and V attempt to create specific components of a transformed system.
- Recovery-oriented in the broad sense.
- Requires counties to describe how strategies are transformational, promote wellness and recovery and how they are consistent, for all strategies, including those on the list.

Other
- Pretty good on list of services, but need more prescription.
- The plan requirements follow a logical structure.

4. Older Adults

Bobbie Wunsch facilitated the older adults discussion group, with DMH staff support from Beverly Abbott and Sylvia Rodriguez.

Section V – System Transformation/Capacity Funding

Housing
- Clarify difference between structural versus service strategies.
  - **DMH Response:** Structural strategies address what structures you need in place, i.e., housing, substance abuse, integrated services. DMH will monitor how the counties shape this.

- Board and care homes: clients must move out at age 60. There is a danger that older adults end up in nursing homes.
- Look at continuum of housing and bring in supports.
- Residential care has a wide spectrum and is complex. Need structural perspective to housing.
- Housing for older adults and transition-age adults has not been addressed systemically.
- Address skilled nursing facilities (SNF) in supported housing.
- Housing should include a continuum of care to assisted living. Address client's need at their functional level.
- Housing should be relevant to client needs and functioning.

Transition-Age Adults
- Under service structure, separate the two.
- It is challenging to mix older adults and transition-age adults.
- Including transition-age adults with older adults is an error. There should be a fifth age group.
- Transition-age adults get very little notice and the issues facing them are not addressed.
- There is a big difference between 55 and 85.

Older Adult Focus
- Senior warm line is needed.
- Coordination of care for frail 80-100 year olds when they get to a place where they are unable to communicate.
- Wraparound is an example of how funding can be used.

Integrated Services
- Page 26: structural strategies: add integrated services.
- Page 28, paragraph 2: self-help centers can help resolve the integration of physical and psychiatric needs and services.
- Structural supports need physical and mental health in one place.
- Do not see anything about psychiatric access with complex medical and acute hospital inpatient services.

Other
- Services and treatment are very different and should be addressed that way.

Section VI – System Capacity

- This section does not lend itself to expanding services or capacity.
- "Ethnic" needs to be changed to "cultural" to include gay community.
- No requirement to look at expertise in the provider network.
- Direct vs. supportive services is confusing. This would do well in a glossary.
- For interpretation staff, verify mental health experience, education and training.

- Peer counseling should be a paid position, not only volunteer.

Section VII – Work Plan

- Page 29 1(c): the implication is that we are to submit a strategy list. Will DMH expect this?
  - **DMH Response:** Yes.
- What about counties that cannot do this?
  - **DMH Response:** This is being addressed in the small county discussion.
- Page 30: assumes there is an existing system of care, when there is not. It also assumes system capacity is in place.
- Page 32(b)(i): divide the category.
- Emphasis should be services statewide.
- Should transition-age adults be considered in the scope of work for adults or older adults?
- Consider adding a category to include transition-age adults, 55 – 59 years. (Consensus was reached on this.)
- Older adults have more complex issues.

Section IX – Local Review and Public Hearing

- Outreach to older adults where they usually congregate.
- Will there be a way for counties to share ideas with one-another?
- What is the process to obtain input from really frail older adults to participate in the process?
- Hand out a simple, written survey on an individual basis in adult health care centers, and provide incentives to complete.
- Use existing networks, such as Meals on Wheels.

Overall Concerns with the CSS DRAFT Plan Requirements: Older Adults

Process and Other Clarifications Needed

- All communication for the plan depends on Internet use.
- Concern about parallel processes in counties.
- Not tied to other pieces of the plan, such as the flow chart.
- Separate pots of money.
- All meetings are in Sacramento.
- Is it too late to integrate all this information?
  - **DMH Response**: The deadline is April 11.

Accountability and Outcomes

- Enrollment: if enrollment is tied to outcomes. On the other hand, it is hard to provide services to all those who need it.

- Quality of life must be considered.

Services
- Consider senior warm line.
- New services exist: training in place so that these ideas are really lived out so services are provided adequately.
- People in neighborhoods must tell us what services they need.

Parity
- Does not address parity across age groups.
- Older adults do not have parity.

Cultural Competence
- Ethnic concern throughout. Need to change to cultural or "ethnic/cultural."
- Process should be culturally diverse.

Other
- Transition-age adults is a missing link.
- Do not raise hope for things that cannot be delivered.

Overall Strengths of the CSS DRAFT Plan Requirements or the Overall Process: Older Adults

- Enrollment, because it reflects a "slice" of parity.
- Directing counties to help families and help people with Alzheimer's.
- Process gives opportunity to be creative.

B. Wrap Up Session

At the wrap-up session at the end of the meeting, a representative of each age-based group presented a summary of their major concerns and the major strengths of the overall CSS DRAFT Plan Requirements. Below is a chart which summarizes these major concerns and strengths and shows the overlap among age-based groups, where it exists.

Summary of Major Concerns	**Children & Youth**	**Transition-Age Youth**	**Adults**	**Older Adults**
Reads too much like an adult document based on AB 2034.	X	X		X
Enrollee-based system does not work for children and families.	X	X		
Does not work for children's services programs and children's system of care.	X			
Does not mandate enough youth and family involvement at community level and at decision-making level.		X		
Needs to address parity among age groups.				X
The capacity section does not ask for competence in youth development.		X		
Involuntary services should not be funded with MHSA funding.		X	X	
Focus on client empowerment throughout the document.			X	
Clarify what is a requirement, recommendation and guideline.			X	
Housing, especially permanent housing and alternatives to IMDs and hospitalization.			X	
Identify older adults outcomes using Older Adults Demonstration Project.				X
Need a position paper on older adults, using the Older Adult Framework.				X
Need to outreach to transitional adults and older adults where they congregate.				X
This process is raising expectations and hopes, which may not be achievable.				X
While document addresses cultural competence, it must also include competence in working with the gay, lesbian, bisexual, and transgender communities.		X		X
Process needs to be more culturally diverse.				X

Summary of Major Strengths	**Children & Youth**	**Transition-Age Youth**	**Adults**	**Older Adults**
Level of stakeholder involvement.	X		X	
Strikes good balance between prescriptive and flexible.	X			
Gives opportunity for creativity.				X
Emphasizes partnerships, family partnerships and agencies.	X			
Very inclusive about who is going to get services. It levels the playing field.		X		
Recognizes the MHSA vision as a positive attempt toward transformation and has a recovery orientation.			X	
Having an older adult section is exciting.				X
Gives exposure to older adults issues.				X
Enrollment gives parity among age-groups.				X

Ms. Hood explained that staff were compiling summaries of all comments from the meetings, email, telephone and letters. DMH will continue to accept input until April 11. At the general stakeholder meetings on April 5 and 6, she will present the major issues raised by stakeholders and how the Department plans to approach them.

Stakeholder Questions

Stakeholder Question: Will the financial discussion at the March 30 workgroup be integrated into the final plan?
DMH Response: Yes. DMH must still provide the supplantation maintenance of effort document. It is not ready yet.

Stakeholder Question: Thank you for doing the examples. Can our county serve existing clients before serving the new people?
DMH Response: DMH has established criteria for whom the MHSA should serve. The Department has recommended unserved and underserved who are at risk of homelessness or jail. But counties can include underserved as long as they can justify it.

Stakeholder Question: When will counties find out how much they can apply for?
DMH Response: This planning estimate by county will be part of the DMH release on May 1.

Ms. Wunsch concluded the meeting by reminding everyone to complete an evaluation and thanked the facilitators of the client and family member pre-meeting age-based groups.